Section of Orthopædics

President—A. ROCYN JONES, F.R.C.S.

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Metatarsus Primus Elevatus.—C. LAMBRINUDI, F.R.C.S.

The patient, Mrs. M., consulted me on account of the extreme fatigue in her feet which she experienced after walking about a quarter of a mile. She had no particular local pain but the fatigue was sufficient to interfere with her normal life and happiness. One suggestive remark she made was that her feet wobbled and felt unstable. Her unsteadiness was very evident when she walked; she appeared to have a hallux flexus but no rigidity, and on closer inspection it seemed as if the head of the 1st metatarsal bone was lying on a higher plane than that of the other four—so much so that when she wobbled she flexed her big toe at the metatarsophalangeal joint in order to balance herself. It was her inability to balance that seemed to be the main trouble. The 1st metatarsal head being on a higher plane, she could bring the inner segment of the foot into action only by flexing the big toe at the metatarsophalangeal joint.

Through a dorsal incision I exposed the metatarsophalangeal joint and by depressing that bone so as to make the head of the 1st metatarsal come into alignment with the others, a gap of quite $\frac{1}{3}$ in. was left. This was filled up with bone graft and the foot put in plaster—a perfectly simple operation. I dealt with the left foot first. The deformity was quite corrected and the foot was so comfortable that she asked me to treat the right one in the same way (*see* Plates I and II).

I believe this is an instructive case, as it is quite possible that such a condition may be responsible for a certain number of cases of hallux rigidus occurring in later life. It may also explain the common association of hallux rigidus and valgus foot, since it is only by putting the foot in valgus that the 1st metatarsal head can bear weight. Morton has suggested hypermobility of the inner segment of the foot as a cause of weakness and pain, but at the operation the joint seemed perfectly stable.

The skiagram of the foot of a child of 14 (*see* Plate I) shows a condition almost identical with that of Mrs. M.—a fact which suggests that the deformity is congenital.

Reports on the following cases were also given, with demonstrations:—

(1) Fragilitas Ossium. (2) Dystrophy of Bone.—G. F. G. BATCHELOR, F.R.C.S.

(1) Fracture of Ankle with Spina Bifida. (2) Myositis Ossificans of Adductors. (3) Traumatic Periostitis of Tibia.—E. P. BROCKMAN, M.Ch.

Pathological Fracture of Humerus (further report on case shown November 2, 1937).—F. F. RUNDLE, F.R.C.S.

Pellegrini-Stieda Disease.—ERNA H. JEBENS, F.R.C.S.

(1) Fracture Dislocation of Ankle. (2) Giant Cell Tumour, Upper End of Tibia: Skiagrams to show progress. (3) Giant Cell Tumour at Lower End of Femur. (4) Subperiosteal Incarceration of Fractured Capitellum.—NORMAN CAPENER, F.R.C.S.

Fracture Dislocation of Spine.—B. WHITCHURCH HOWELL, F.R.C.S.